



**Karolinska
Institutet**

Karolinska Institutet

<http://openarchive.ki.se>

This is a Peer Reviewed Accepted version of the following article, accepted for publication in The British journal of psychiatry : the journal of mental science.

2016-03-01

Improving risk assessment in schizophrenia : epidemiological investigation of criminal history factors

Witt, Katrina; Lichtenstein, Paul; Fazel, Seena

Br J Psychiatry. 2015 May;206(5):424-30.

<http://doi.org/10.1192/bjp.bp.114.144485>

<http://hdl.handle.net/10616/45049>

If not otherwise stated by the Publisher's Terms and conditions, the manuscript is deposited under the terms of the Creative Commons Attribution-NonCommercial-NoDerivatives License (<http://creativecommons.org/licenses/by-nc-nd/4.0/>), which permits non-commercial re-use, distribution, and reproduction in any medium, provided the original work is properly cited, and is not altered, transformed, or built upon in any way.



**Karolinska
Institutet**

This is an author produced version of a paper published in **The British journal of psychiatry**. This paper has been peer-reviewed but does not include the final publisher proof-corrections or journal pagination.

Citation for the published paper:

**Witt, Katrina Lichtenstein, Paul; Fazel, Seena,
"Improving risk assessment in schizophrenia:
epidemiological investigation of
criminal history factors. Br J Psychiatry.
2015 vol 206 issue 4: pp 424-430**

DOI: **10.1192/bjp.bp.114.144485**

Access to the published version may
require subscription.

This is an author-produced electronic version of an article
accepted for publication in the British Journal of Psychiatry.
The definitive publisher-authenticated version is available
online at <http://bjp.rcpsych.org>

Improving risk assessment in schizophrenia: An epidemiological investigation of criminal history factors.

KATRINA WITT D.Phil,¹ PAUL LICHTENSTEIN PhD,² & SEENA FAZEL MD.^{1*}

¹ University of Oxford, Department of Psychiatry, Warneford Hospital, Oxford, OX3 7JX, UK.

² Department of Medical Epidemiology and Biostatistics, Karolinska Institutet, Stockholm, Sweden.

* Author to whom all correspondence should be sent:

Dr. S. Fazel
University of Oxford,
Department of Psychiatry,
Warneford Hospital,
Oxford, OX3 7JX, UK.

Tel.: +44 1865223784.

Fax: +44 1865793101.

E-mail: seena.fazel@psych.ox.ac.uk.

Main Body Word Count: 3,498.

Number of Figures: 0

Number of Supplementary Figures: 0

Number of Tables: 5

Number of Supplementary Tables: 4

Abstract

Background: Violence risk assessment in schizophrenia relies heavily on criminal history factors.

Aim: To investigate which criminal history factor or factors are most strongly associated with violent crime in schizophrenia.

Methods: 13,806 individuals (8,891 males and 4,915 females) with two or more hospitalizations for schizophrenia were followed until convicted for a violent offence. Multivariate hazard ratios for 15 criminal history factors included in different risk assessment tools were calculated. The incremental predictive validity of these factors was estimated using tests of discrimination (c-index), calibration (likelihood ratio), and reclassification (R^2).

Results: Over a mean follow-up of 12.0 years, 17.2% of males ($n=1,353$) and 5.7% of females ($n=281$) were convicted of a violent offence after diagnosis. The three criminal history factors most strongly associated with subsequent violence for both males and females included: a previous conviction for a violent offence, assault, illegal threats and/or intimidation, and imprisonment. However, only a previous conviction for a violent offence was associated with incremental predictive validity in both genders following adjustment for young age and comorbid substance use disorder (associated with an increase in the c-index in men of 4.2% and in women of 5.3%; change in reclassification was 6.8% and 13.4% for men and women respectively).

Conclusions: Clinical and actuarial approaches to assess violence risk can be improved if included risk factors are tested using multiple measures of performance.

Declaration of Interest: None.

Introduction

Although there is strong evidence that patients with schizophrenia are at increased risk of violence compared to the general population,¹ and current treatment guidelines in both the UK² and USA³ recommend that violence risk should be assessed in all patients, there is uncertainty over the best method to do this. Current approaches rely on a combination of clinical opinion, which some have argued is unreliable,⁴ and structured tools which have not been validated in patients with schizophrenia⁵ and have mixed evidence for their predictive accuracy.⁶ In clinical practice, regardless of the approach used, criminal history factors are integral to any assessment.⁷ Consequently all violence risk assessment tools include them and many weight them heavily in deriving risk categories. There is considerable variation, however, in which criminal history items are included and a recent meta-analysis found large differences in their strength of association.⁸ A review of commonly used tools found that 14 different criminal history factors are currently included in existing commonly used risk assessment tools.⁵ Identifying the criminal history factor with the most predictive accuracy may, therefore, improve the assessment of risk.

We therefore investigated the strength of association for a number of criminal history risk factors using a longitudinal dataset of 13,806 individuals diagnosed with schizophrenia over a 22 year period. We also investigated which factors incrementally improved risk prediction beyond known risk factors in men and women separately. We separated genders as recent work suggests that the strength of association for some criminal history risk factors may differ by gender.^{9, 10} In addition, as many patients will not have a criminal history, we investigated whether family criminal factors were associated with violent crime in those without a criminal history before diagnosis with schizophrenia.¹¹

Method

Sample

Using the ten digit identification number assigned to all Swedish residents, including migrants,¹² several Swedish population-based registries were linked. Firstly, the Swedish Hospital Discharge Register (HDR) was used to identify all persons diagnosed with schizophrenia according to either the eighth (1973–1986; code 295), ninth (1987–1996; code 295) or tenth (1997 onwards; code F20) revisions of the International Classification of Disease (ICD). The HDR is an accurate record of the prevalence of schizophrenia in Sweden as less than one per cent of discharge records had missing personal identification numbers between 1988 and 2000.¹³ Additionally, HDR diagnoses demonstrate good concordance when compared to diagnoses made according to DSM-III-R¹⁴ or DSM-IV criteria.¹⁵⁻¹⁷ As previous research has used two diagnoses to improve diagnostic specificity,¹ we included all individuals with at least two separate discharge diagnoses of schizophrenia between January 1, 1973 and December 31, 2004.

Censoring due to death or emigration was identified from the Cause of Death Register (CoD) and Migration Register respectively. The CoD records information on an individual's date, location, and cause of death (as recorded on their death certificate) according to the ICD. The CDR has been reported to be 99.7% complete.¹⁸ The Migration Register records the date an individual emigrates from Sweden, provided they are leaving for a minimum period of one year.¹⁹

Lastly, the Multi-Generation Register (MGR) was used to link each participant to their mother and father. As the MGR records the PIN of an individual and their parents,²⁰ it is possible to use the MGR to identify an individual's mother, father, and siblings. By linking this

information with the National Crime Register (NCR), information on whether an individual's mother, father, or siblings have been convicted of any offences in Sweden can also be ascertained. The MGR has good coverage: only 16% of individuals have missing information on parents.²¹

Statistics Sweden, an independent Government agency, manages the administration of these population registries. This agency merged the registries and assigned each participant an identification number specific to this study. The coding sheet which linked the ten digit identification number to the study identification number was then destroyed to ensure anonymity, as per a previous study.²² The Karolinska Institutet Ethics Committee gave approval for the study (number: 2005/174-31/4).

Measures

Violent crime

Data on convictions for violent offences were obtained from the NCR. Coverage of the NCR is complete; only 0.001% of convictions recorded between 1988 and 2000 were missing personal identification numbers.¹³ Violence was determined from conviction data for two reasons. First, criminal cases cannot be resolved without conviction through plea bargaining or by pleading not guilty by reason of insanity in Sweden. Second, conviction data is recorded in the NCR even if the individual is sentenced to a non-custodial sentence, is transferred to a forensic psychiatric institution at sentencing, or receives a fine or caution.²³ For these reasons the NCR reflects the extent of resolved criminality in Sweden.²³

Violent convictions were defined as convictions for homicide, aggravated assault, common assault, any sexual assault (e.g., rape, sexual coercion, and child molestation),

aggravated robbery, robbery, kidnapping, arson, and illegal threats or intimidation. Attempted offences were also included, where relevant. The decision to include threats and intimidation as violent offences is consistent with work in this area.^{1, 13, 22-25}

Criminal history risk factors

Criminal history risk factors were coded from the crime register. In this study we used risk factors identified from a review of the existing literature⁸ and from a systematic review of items included violence risk assessment tools.⁵ We also investigated other criminal history risk factors that have been used in risk assessment but have not been replicated and are therefore not included in previous reviews (Table S1 for males and S2 for females). A full description of the coding used for each criminal history risk factor reported in this study is provided in Table S3.

Analyses

As we were concerned with identifying the criminal history risk factors that predict violence risk in those with schizophrenia, for the purposes of the present study, those convicted of a violent offence subsequent to their diagnosis with schizophrenia were considered to be violent offenders. Individuals were therefore followed from the date of second discharge from hospital with a diagnosis of schizophrenia until conviction for a violent offence, death, emigration or end of follow-up (December 31, 2004), whichever came first. We excluded periods in prison and forensic psychiatric hospitalization from time at risk. As almost all prisoners in Sweden are released on parole after serving two-thirds of their sentence^{26,27} (for sentences over one month's duration), time spent in custody was calculated adjusting for this. Only 1.8% of the custodial sentences received by this cohort were for one month or less.

Cox proportional hazards regression was used to investigate the association between each criminal history risk factor and time until conviction for a violent offence. Cox regression generates hazards ratios (HRs) and accompanying 95% confidence intervals (CIs) which represent the ratio of the event rate. The proportional hazards assumption was assessed from the plot of the scaled Schoenfeld residuals. The residuals for all risk factors formed approximately parallel lines, suggesting there were no major violations of the proportionality assumption.

Univariate associations between each criminal history risk factor and violence were calculated separately for males and females. As univariate HRs do not indicate whether a novel risk factor contributes meaningfully to the prediction of risk in clinical practice,²⁸ we followed standard guidelines in general medicine for evaluating the incremental validity of novel risk factors,²⁹ by investigating their predictive value when added to a baseline model of age and diagnosis with a substance use disorder (SUD); based on a lifetime diagnosis on the HDR according to ICD criteria. We chose to adjust for these factors as they have been identified as independently associated with violence risk in prior epidemiological work.^{1, 30} Age was measured at the point of the second discharge diagnosis of schizophrenia and was dichotomised as is typically done in risk assessment. We used < 32 and ≥ 32 years as this cut-off best discriminates risk groups in this dataset.²² In a sensitivity analyses, we also modelled age as a linear variable instead of a dichotomous one.

In addition to remaining significantly associated with violence following adjustment for age and comorbid SUD, a clinically important risk factor must also demonstrate an improvement in discrimination, calibration, and reclassification.³¹ Consequently, estimates of improvement in discrimination, calibration, and reclassification were calculated for each criminal history risk factor. Discrimination, which refers to the ability of a model to distinguish between those who do

and do not have the outcome of interest, was assessed using Harrell's c-index.³² The c-index, which ranges from 0.5 to 1, with 1 demonstrating perfect discrimination, assesses the probability that a violent person scores higher than a non-violent person.³³ The c-index can be interpreted like an AUC, but has the advantage that it allows for censoring and is therefore preferred for survival analyses.³⁴ Calibration, which examines goodness of fit, was assessed statistically using the Likelihood Ratio Test. This indicates whether the addition of a new risk factor significantly improves model fit. Additionally, work also suggests that reclassification, may be important when determining the incremental predictive validity of a novel risk marker.³¹ Reclassification indicates whether the addition of a criminal history risk factor improves the proportion of variance explained by the model, and was assessed using change in Royston's R^2 .^{35, 36} Although there are presently no guidelines to determine how these measures should be combined, in other research a risk factor with the best performance would be the one with the an increase of at least 0.5% in the c-index, with adequate calibration.³⁷ If there are many factors that meet these two criteria, we interpreted the risk factor associated with the greatest increase in both the c-index and Royston's R^2 as important for the assessment of violence risk. All analyses were made using Stata version 11.³⁸

Subgroup Analysis

Criminal history risk factors were also assessed separately for males with and without a history of criminal conviction prior to diagnosis with schizophrenia (Table S4). Given the small number of events involved, these additional analyses were not conducted for females.

Results

We identified 8,891 (54.4%) males and 4,915 (35.6%) females diagnosed with schizophrenia between 1973 and 2004. Average age at diagnosis for males was 29.2 yrs ($sd=7.0$, range 18-48) and for females 29.0 ($sd=7.4$, 18-49) (Table 1). Average duration of follow-up, excluding years spent in custody, was 11.5 yrs ($sd=8.2$, 0.08-30.8) for males, and 12.7 ($sd=8.1$, 0.1-30.8) for females.

TABLE 1 HERE

Univariate Analyses

In men, 1,535 (11.1%) were convicted of a violent offence. The most common violent conviction for these males was for illegal threats (45.7% of violent males), followed by common assault (33.7%), sexual offences (6.3%), arson (3.6%), aggravated assault (3.5%), robbery (3.2%), homicide (2.7%), and kidnapping (1.1%). Of the criminal history factors identified from previous reviews as being predictive of risk, a previous conviction for assault, a violent offence, and having served a term of imprisonment were all strongly associated with violent crime after discharge (Table 2). We also investigated factors included in some risk assessments, although they have not been emphasized in previous systematic reviews, and found some of these were associated with violent crime, notably: conviction for illegal threats and weapon use. When age was modelled continuously, there were no material changes to these associations (results not presented).

TABLE 2 HERE

Fewer women were convicted of a violent offence following diagnosis with schizophrenia ($N=281$, 5.7%). The most common violent conviction for these women was for threats and intimidation ($n=123$, 43.7%), followed by common assault ($n=88$, 31.3%), arson ($n=39$, 13.8%), aggravated assault ($n=17$, 6.0%), homicide ($n=7$, 2.5%), robbery ($n=3$, 1.0%) and sexual offences ($n=2$, 0.7%), and kidnapping ($n=2$, 0.7%). Similar risk factors to men were strongly associated with violence in females. A previous conviction for weapon use, however, was more strongly associated with subsequent violence in females (Table 3). As with males, modelling age as a continuous, rather than as a dichotomous variable, did not materially change these associations (results not presented).

TABLE 3 HERE

Subgroup Analysis

Of those males with a criminal history prior to diagnosis with schizophrenia ($n=4,502$, 50.6%), a total of 484 (11.0%) were convicted of a violent offence during follow-up. The most common conviction was for threats and intimidation ($n=197$, 40.7%), followed by common assault ($n=176$, 36.3%), sexual offences ($n=40$, 8.2%), arson ($n=25$, 5.1%), aggravated assault ($n=16$, 3.3%), robbery ($n=14$, 2.9%), homicide ($n=11$, 2.2%) and kidnapping ($n=5$, 1.0%). The factors most strongly associated with violence in this group were similar to those for males in the overall cohort (Table S3).

None of the familial criminal history risk factors were significantly associated with increased violence risk for those males who were not convicted of a violent offence prior to diagnosis with schizophrenia ($n=4,389$, 49.3%) (results not presented).

Discrimination, calibration, and reclassification analyses

We investigated all the factors for discrimination, calibration, and reclassification. This analysed whether they added incremental predictive accuracy to a baseline model of young age (<32 years) and comorbid SUD. We found that a previous conviction for a violent offence is an important risk factor for this population as it was associated with the greatest increase in the c-index and Royston's R^2 although adjusted HRs were similar to those for some other factors (Tables 4 and 5). For men, the adjusted HR for previous violent conviction was 2.3 (95% CI 2.1 – 2.6), resulting in a c-index of 69.4 for the adjusted model including age and comorbid SUD.

TABLE 4 HERE

For women, the adjusted HR for a previous violent conviction was 5.1 (95% CI 3.7 – 7.2). When included in a model with age and SUD, this led to a c-index of 69.6%. When age was modeled as continuously, similar results were found for both genders (results not presented).

TABLE 5 HERE

In a second model (Model 2, Table 4), we investigated the incremental predictive validity of adding the remaining criminal history factors to a model that included young age, comorbid SUD, and conviction for a violent offence. For this model, collinear variables were not included, and although adjusted HRs were significant, small increases in both the c-index and Royston's R^2 were observed for most variables. In women (Model 2, Table 5), however, adding a

history of a non-violent offence may improve prediction. When age was measured continuously, there was no material difference to these findings (results not presented).

For males with a history of criminal offending prior to diagnosis, a previous conviction for a violent offence was also associated with the largest increase in the c-index (results not presented).

Discussion

Criminal history risk factors are frequently weighted most heavily in the assessment of violence risk. Previous work, however, suggests there is considerable variability in the strength of association for these risk factors in those with psychosis.⁸ In this study, we examined which of these previously identified criminal history factors best predicted conviction for a violent crime in a population cohort of 13,806 individuals with schizophrenia who were followed for an average of 12 years.

This study provides some precision as to the relative strength of different criminal history risk factors in individuals with schizophrenia. Whilst univariate analyses showed that a number of criminal history risk factors were associated with violent crime in both males and females with schizophrenia, when these were added to a baseline model incorporating young age and comorbid SUD, a history of violent conviction led to the greatest increase in discrimination (which indicates the probability that a violent individual scores higher than a non-violent individual), calibration (which indicates goodness of fit), and reclassification (which can be interpreted as indicating the change in predicted risk for an individual following the addition of a novel risk factor).³⁹

In contrast to expert opinion,^{9, 10} results of the present study suggest that similar criminal history risk factors are associated with violence in both males and females with schizophrenia. However, the relative strength of these risk factors appears to differ by gender. A conviction for weapon use, for example, was more strongly associated with violence in females (unadjusted HR=8.7) than in males (unadjusted HR=2.5). This is likely due to the low base rates of such risk factors in women, and in our study 0.6% of women were convicted for weapon use compared to 4.3% of men.

One implication of our study is the demonstration of the importance of looking beyond univariate analyses in the construction of risk prediction rules. We have proposed one approach to this, which has been validated in cardiovascular medicine,²⁹ where the incremental predictive accuracy to existing risk models needs to be examined. Thus, we would suggest that future work should investigate whether any novel risk factors add to a baseline risk model including young age, comorbid substance abuse, and a previous violent conviction. Although all currently used violence risk assessment instruments include criminal history items,⁵ we found that a number of the items included in these instruments may not contribute to the prediction of violence in schizophrenia. These factors included previous convictions for sexual offences in males, and possibly a parental history of violent offending in females.

In a subgroup analysis, we investigated whether the relative strength of these criminal history risk factors varied for men with and without a criminal history prior to diagnosis with schizophrenia. In men with a criminal history, similar risk factors were significantly associated with violence risk. In those without an offending past, no familial criminal history factors were significantly associated with violence risk.

The causes of violence are multifactorial, however, reflecting a number of genetic, historical, environmental and clinical risk factors.⁴⁰ The assessment of violence risk in this population should therefore be aware of the interplay of various background factors, and individual differences on how they impact on patients. It is therefore important to highlight that the pathways and mechanisms leading to violence in patients with schizophrenia should not be reduced to one set of risk factors. However, the focus of the current study is the assessment of violence risk rather than its aetiology, and we have investigated which of the heavily weighted criminal history factors should be part of clinical risk assessment.

Strengths and Limitations

The use of nationwide data enabled this study to achieve a sample size which is several orders of magnitude larger than previous investigations into criminal history risk factors for violence in individuals with schizophrenia. A novel feature of this approach is that the present study was able to investigate risk factors for violent crime separately for women with schizophrenia. To our knowledge, only one other study of 304 women with psychosis has done this, finding that a history of imprisonment was significantly associated with subsequent violence but, contrary to our findings, that assault was not.⁴¹

Criminal history risk factors analysed in this study were coded from official register-based data. Therefore, the prevalence of violence in this study may underestimate the true extent of criminality in this population.²³ As this was not a study of prevalence but of risk factors, however, the use of relatively hard outcome measures means that findings may be more generalizable to non-Scandinavian countries. Furthermore, it also allowed for a large sample and long follow-up than a study based on clinical interviews with patients. However, it does mean that more sensitive measures of violence that did not lead to conviction were not included, and their relative contribution to risk prediction needs further research. When more sensitive measures are used, such as a combination of both self- and collateral-reported violence, previous violence nonetheless represented the strongest indicator of subsequent violence risk in previous work.⁴²

Another limitation is that we restricted our cohort to patients hospitalized on at least two separate occasions with schizophrenia. This is consistent with previous work using this cohort. Additionally, this decision was made to improve diagnostic specificity. This meant that although all crimes before second diagnosis were included in our analyses, these were, however, classified

as criminal history factors. Further work will therefore need to investigate whether our findings are generalizable to first episode psychosis. We have shown previously that there are similar base rates of violence in those individuals with only one discharge diagnosis for schizophrenia as compared to those with two or more diagnoses,¹ suggesting some generalisability.

The prevalence of schizophrenia in Sweden is also very similar to that reported from other high-income countries according to a large meta-analysis.⁴³ In addition, the median prevalence rate of the broader category of psychosis at 1.0% has little variation across European countries.⁴⁴ Finally, age-adjusted DALYs for schizophrenia are very close for Sweden (186), the UK (185) and the US (186).⁴⁵ Sweden also has a similar rates of violent crime per head of population compared to most Western European countries,⁴⁶ although it does have a lower rate of homicide than countries with more liberal gun ownership laws such as the US.¹³ As homicide is rare (accounting for 2% of the violent convictions in our sample), our findings are more relevant to general psychiatry than purely focussing on homicide outcomes.

The most common conviction in our cohort was for threats and/or intimidation. This high proportion is not dissimilar to one other study, based on mentally ill offenders convicted of more serious violent offences in England and Wales.⁴⁷ Other population studies on the association between violence and schizophrenia have not reported individual offence categories.⁴⁸ Further work on the prevalence of individual violent offence types is therefore required to ascertain the generalisability of this finding to other jurisdictions.

Finally, although there have been no major changes to the definition for different offences within the Swedish legal system over the previous decade, the precise legal categories will vary by country.

Conclusions

This study suggests that a conviction for a violent crime prior to diagnosis may be the strongest predictor of subsequent convictions for violence in those with schizophrenia. Clinical assessment should prioritise this factor among the criminal factors investigated, and risk assessment tools should consider incorporating it into their schemes. Novel risk factors for predicting violence in schizophrenia need to consider incremental predictive validity beyond baseline models that include previous violent conviction, young age, and comorbid substance abuse.